General Assembly of Tennessee
OFFICE OF LEGAL SERVICES
War Memorial Building
Nashville, Tennessee 37243-0059

April 16, 2009

MEMORANDUM

TO: Marcia Garner

FROM: Fred Standbrook, Legislative Attorney

SUBJECT: Rules Filed with Secretary of State

Pursuant to Tennessee Code Annotated, Section 4-5-226, on Monday, April 27, 2009, in Room 30 of the Legislative Plaza, the House and Senate Government Operations Committees will meet jointly to consider rules filed with the Tennessee Secretary of State. Attached are an agenda and a copy of the rules filed by your agency that will be considered.

The House and Senate Government Operations Committees are launching a new procedure to enhance its review of promulgated rules. A consent calendar of rules will be prepared each month. If the rules you are to present are on the consent calendar you do not have to attend the rule review meeting.

Any member of the Government Operations Committees can request a rule be removed from a proposed list of rules to be placed on the consent calendar. There are no objective or empirical criteria for rules that are included on the consent calendar and for those which are not. Whimsy and serendipity shall be the only constants in determining the consent calendar. Imploring and threats will not alter the outcome of this decision.

If the rules you are to present are on the consent calendar you will be notified. If you do not receive notification then you should attend the rule review hearing. Notice regarding the consent calendar will be given as soon as practicable. I shall strive for at least a 2-business day notice, but reserve the right to fudge this

deadline. Please be advised that a rule on a consent calendar may be considered at a later hearing. If a rule is to be considered at a later hearing notice will be provided.

At the hearing you should give a brief explanation of the rules and state whether these rules are new rules or are amendments to existing rules. If the rules under consideration are permanent rules you should also inform the committees whether these rules have previously been the subject of a rulemaking hearing. At the end of your presentation you should ask if there are any questions from the members of the committees.

If someone rather than you will be presenting the attached rules, or you are unable to attend the rule review meeting, please notify me so suitable arrangements can be made.

If you have any questions regarding this matter, please call me at your convenience at 741-9508.

FS:sn

AGENDA

RULE REVIEW

GOVERNMENT OPERATIONS COMMITTEES

April 27, 2009

Room 30 – Legislative Plaza – 1:00 P.M.

G.O.C. STAFF RULE ABSTRACT

DEPARTMENT:	Department of Human Services
DIVISION:	Medical Services
SUBJECT:	Technical and Financial Eligibility Requirements for Medicaid; Qualified Long Term Care Insurance Policy Rules
STATUTORY AUTHORITY:	Tennessee Code Annotated, Sections 71-1-105(12), 71-3-153, 71-5-102, and 71-5-109
EFFECTIVE DATES:	May 10, 2009 through June 30, 2010
FISCAL IMPACT:	The Agency reports that amendment of Rule 1240-03-03-.02(9) is not anticipated to increase state expenditures because Long Term Care Partnership insurance would only protect resources of individuals who have a qualified insurance policy that would otherwise pay for a portion of an individual's cost of care in a long term care setting, and Rule 1240-03-01-.02(2)(b) would define caretaker relative in the Standard Spend Down Program (SSD) program as currently defined in Section 1931 (AFDC-MO) under which the State currently operates.

STAFF RULE ABSTRACT:

Rule 1240-03-01-.02(1), alphabetically at (c) and (u) at Definitions, is being amended to insert definition of Caretaker relative under the Standard Spend Down Program (SSD) and definition of Qualified Long Term Care Insurance Policy, respectively.

Rule 1240-03-01-.02(2)(b) at Definitions is being amended to insert definition of Caretaker relative under the SSD.

Rule 1240-03-03-.02(9) at Technical Eligibility Factors is being amended to add provision concerning qualified long term care insurance policies, and excluding assets, when determining eligibility for nursing home Medicaid and continuing to exclude the assets when recovering benefits from the estate, up to the amount of benefits paid under the long term care insurance policy.

The Long Term Care Partnership (LTCP) program involves private long term care (LTC) insurers, the Bureau of TennCare, the Department of Human Services and the Tennessee

Department of Commerce and Insurance (TDCI). LTCP is overseen by the Centers for Medicare and Medicaid Services (CMS), and each state is given flexibility in how the program is administered at the state level. In Tennessee, qualified LTCP policies must provide a specific amount of inflation protection based on the person's age when the policy is purchased and must meet other requirements determined by TDCI.

In order to participate in TennCare's LTCP program, a person must have purchased and received the benefits of a qualified LTCP policy. A person who requests TennCare payment of LTC services after exhausting some or all benefits of a LTCP policy may have certain assets "disregarded" equal to the benefits paid by the LTCP policy at the time the person is determined eligible for TennCare. These assets are not counted when the person's TennCare eligibility is determined and will not be recovered during estate recovery when the person dies.

Regulatory Flexibility Addendum

Pursuant to Public Chapter 464 of the 105th General Assembly, prior to initiating the rule making process as described in § 4-5-202(a)(3) and § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

The Centers for Medicare and Medicaid Services (CMS) approved TennCare's proposed State Plan amendment number 08-001 on May 13, 2008, with an effective date of October 1, 2008. This State Plan amendment adds requirements for long term care partnership insurance policies and eligibility asset and estate recovery exclusions. This amendment implements Section 6021 of the Deficit Reduction Act of 2005.

This State Plan amendment approval requires TennCare to allow an individual who is a beneficiary under a long term care insurance policy that meets certain requirements to be given a resource disregard for the amount of benefits paid by the policy for the individual. The amendment also requires TennCare not to seek recovery from the estate of a TennCare enrollee for the amount of benefits paid by the qualified long term care insurance policy. Sales of qualified long term care insurance policies will begin in the state of Tennessee on or after October 1, 2008. These rules are necessary to implement the long term care partnership policy as approved in State Plan amendment 08-001.

For purposes of Acts 2007, Chapter 464, the Regulatory Flexibility Act, the Department of Human Services certifies that these rulemaking hearing rules substantially codify existing federal law at 42 U.S.C. § 1396p(b)(1)(C)(iii) and (b)(5) of Title XIX of the Social Security Act, concerning qualified long term care insurance policies such that pursuant to Section 6 of the Regulatory Flexibility Act, the Regulatory Flexibility Act's provisions do not apply to these rules.

In addition, these rulemaking hearing rules do not appear to affect small businesses as defined in the Act because these rules will only affect Tennessee's long term care population who are not employable.

"REDLINE VERSION-RULE 1240-03-01-.02 DATED FEBRUARY 6, 2009"

RULES
OF
TENNESSEE DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

CHAPTER 1240-3-1
GENERAL RULES

1240-3-1-.02 DEFINITIONS.

(1) Definitions of terms or phrases utilized in regulations relating to the Medical Assistance Program are as follows:

(a) Aid to Families with Dependent Children (AFDC). Refers to the name of the cash assistance program for Families and Children prior to the passage of the Welfare Reform Act in July 1996.

(b) Aid to Families with Dependent Children – Medicaid Only (AFDC-MO (Section 1931)). Refers to Section 1931 of the Social Security Act [42 U.S.C. § 1396u-1] which requires that any family group that qualifies for Medicaid based on AFDC-MO regulations prior to July 16, 1996 be tested for eligibility in this group.

(c) Caretaker relative: The father, mother, grandfather or grandmother of any degree, brother or sister of the whole or half-blood, stepfather, stepmother, stepbrother, stepsister, aunt or uncle of any degree, first cousin, nephew or niece, the relatives by adoption within the previously named classes of persons, and the biological relatives within the previous degrees of relationship, and the legal spouses of persons within the previously named classes of persons, even if the marriage has been terminated by death or divorce, with whom a child is living. A Caretaker relative may be included in the AFDC-MO Category if he/she is related in the previous degrees of relationship with a child in the home who is under age eighteen (18) years of age or a child who has not attained nineteen (19) years of age and who is a full-time student in a secondary school or the equivalent and who is expected to graduate by the nineteenth birthday. [TCA § 71-3-153]

(~~c~~d) Categorically Needy. Categorically Needy individuals are entitled to the broadest scope of medical assistance benefits. All recipients of Medicaid based on Section 1931-AFDC-MO and the SSI program for the aged, blind or disabled are Categorically Needy. In addition, many adults, families, pregnant women and children who do not receive cash assistance receive the Categorically Needy level of benefits for Medicaid Only assistance.

(~~d~~e) Code of Federal Regulations (C.F.R.). Federal regulations which transfer to regulatory form the specific requirements of Federal law.

(~~e~~f) Co-insurance. Coinsurance amounts payable by the recipient under the provisions of Title XVIII, Part B for covered medical services rendered under the Medicare Program and becoming due after satisfaction of the deductible liability. [42 U.S.C. §§ 1395j et seq.]

(~~f~~g) Deductible. Amounts payable by the recipient which fall within an aged beneficiary's deductible liability imposed by Title XVIII, Part B. Health Insurance for the Aged. [42 U.S.C. §§ 1395j et seq.]

(~~g~~h) Eligible individual. A person who has applied for medical assistance and has been found to meet all applicable conditions for eligibility pertaining to Tennessee's Medical Assistance Program.

(~~h~~i) Excess income. That portion of the income of the individual or family group, which exceeds amounts allowable to the individual or family group as disregarded income or income protected for basic maintenance and which results in a determination of ineligibility.

1. Excess Resources. That portion of the liquid assets or other resources of the individual or family group in excess of the amounts which may be retained for the individual or family group's security and personal use, not exempted from consideration or otherwise accounted for by special specified circumstances, and which result in a determination of ineligibility.

2. Spenddown. The process by which excess income is utilized for recognized medical expenses and which, when depleted, results in a determination of eligibility if all other eligibility factors are met.

(~~i~~i) Families First (FF) - Tennessee's TANF program (Temporary Assistance for Needy Families) which provides cash assistance to families with dependent children. [42 U.S.C. §§ 601 et seq.]

(~~j~~k) Inpatient services. Those services rendered for any acute or chronic condition, including maternal and mental health care, which cannot be rendered on an outpatient basis.

(~~k~~l) Level I care. Level I care is health care in a nursing facility which is more than room and board, but is less than skilled nursing care. (Level I care was formally called I.C.F. - Intermediate Care Facility).

(~~l~~m) Level II care. Level II care is health care in a nursing facility which is a higher level of care than Level I, but less than inpatient hospitalization. (Level II care was formally called Skilled Nursing Care.)

(~~m~~n) Medicaid. The State program of medical assistance as administered by the Department in compliance with Title XIX of the Social Security Act [42 U.S.C. §§ 1396 et seq.] and which is designed to provide for the medical care needs of Tennessee's medically indigent citizenry.

(~~n~~o) Medical assistance drug list. A listing of drugs covered under the Medical Assistance Program, which includes the drug code, description, dosage strength, covered unit form, maximum dosage covered, and per unit price.

(~~o~~p) Medically Needy – Individuals whose income or resources are under a certain limit and allows them to qualify for Medicaid by spending down their medical expenses.

(~~p~~q) Medicare. The Federal program under Title XVIII of the Social Security Act [42 U.S.C. §§ 1395 et seq.] providing medical benefits to persons receiving Social Security Retirement payments or who have received Social Security benefits based on disability for a period of twenty-four (24) consecutive months.

1. Part A of Title XVIII. Hospital Insurance Benefits provides hospital care, nursing home care, and home health visits, subject to deductibles and co-insurance. [42 U.S.C. § 1395c]

2. Part B of Title XVIII. Supplementary Medical Insurance provides additional medical benefits to those persons eligible for Part A or any person sixty-five (65) years of age, but only if enrolled in the program and paying the monthly premium. [42 U.S.C. § 1395j]

(~~q~~r) Nursing Facility (NF). A facility certified by the State to provide nursing care in what was formally called Intermediate Care Facility (I.C.F.) and Skilled Nursing Facility (S.N.F.).

(~~r~~s) Outpatient services. Services provided, in other than inpatient circumstances, for any condition detrimental to the individual recipient's physical or mental health which cannot be taken care of in the home situation.

(~~s~~t) Poverty Groups – Assistance groups whose gross income does not exceed various percentages of the Federal Poverty Level Income Standard.

(u) Qualified Long Term Care Insurance Policy – A long term care insurance policy issued on or after October 1, 2008, that has been pre-certified by the Tennessee Department of Commerce and Insurance pursuant to State Rule 0780-01-61as:

1. A policy that meets all applicable Tennessee Long Term Care Partnership requirements; or

2. A policy that has been issued in another Partnership state and which is covered under a reciprocal agreement between such other state and the State of Tennessee.

(~~t~~v) Supplemental Security Income (SSI) – A federal income supplement program funded by general tax revenues and is designed to help aged, blind and disabled individuals who have little or no income. Applications for SSI benefits are filed at the Social Security office. Individuals who are eligible for SSI are automatically entitled to Medicaid. [42 U.S.C. §§ 1382 et seq.]

(~~u~~w) Temporary Assistance for Needy Families (TANF) – Program which was created by the Welfare Reform Law of 1996. TANF became effective July 1996 and replaced what was then commonly known as the AFDC program. [42 U.S.C. §§ 601 et seq.]

(2) Definitions of terms or phrases utilized in Medicaid Spenddown, Standard Spend Down and TennCare Standard.

(a) Call-in Line. The toll-free telephone single point of entry used during a period of open enrollment (as announced by the Bureau of TennCare) to enroll new applicants in the Standard Spend Down Program (SSD).

(b) ~~Caretaker relative. The father, mother, grandfather or grandmother of any degree, brother or sister of the whole or half-blood, stepfather, stepmother, stepbrother, stepsister, aunt or uncle of any degree, first cousin, nephew or niece, the relatives by adoption within the previously named classes of persons, and the biological relatives within the previous degrees of relationship, and the legal spouses of persons within the previously named classes of persons, even if the marriage has been terminated by death or divorce, with whom a child is living.~~ Caretaker relative. The father, mother, grandfather or grandmother of any degree, brother or sister of the whole or half-blood, stepfather, stepmother, stepbrother, stepsister, aunt or uncle of any degree, first cousin, nephew or niece, the relatives by adoption within the previously named classes of

persons, and the biological relatives within the previous degrees of relationship, and the legal spouses of persons within the previously named classes of persons, even if the marriage has been terminated by death or divorce, with whom a child is living. A caretaker relative may be considered for SSD if he/she is related in the previous degrees of relationship with a child in the home who is under age eighteen (18) years of age or a child who has not attained nineteen (19) years of age and who is a full-time student in a secondary school or the equivalent and who is expected to graduate by the nineteenth birthday. [TCA § 71-3-153]

(c) Continuous eligibility. Enrollment in a Medicaid Medically Needy, Standard Spend Down or TennCare Standard eligibility category with no break in coverage.

(d) Continuous enrollment. Certain individuals determined eligible for the TennCare Program may enroll at any time during the year. Continuous enrollment is limited to persons in the following two (2) groups:

1. TennCare Medicaid enrollees; or

2. Individuals who are losing their Medicaid, who are uninsured, who are under 19 years of age, and who meet the qualifications for TennCare Standard as "Medicaid Rollovers" in accordance with the provisions of these rules.

(e) Open enrollment. A designated period of time determined by the Bureau of TennCare, during which individuals may apply for enrollment in TennCare Standard or Standard Spend Down.

1. The following individuals may apply for TennCare Standard as uninsured or medically eligible persons during a period of open enrollment:

   (i) Uninsured individuals whose incomes fall within the poverty levels established for the period of open enrollment being held;

   (ii) Individuals qualifying as medically eligible as defined in these rules and whose incomes fall within the poverty levels established for the period of open enrollment being held.

2. Individuals applying for the Standard Spend Down Program may apply during a period of open enrollment announced by the Bureau of TennCare in accordance with these rules.

(f) Standard Spend Down. The demonstration category composed of adults aged twenty-one (21) and older who are not eligible for Medicaid but who meet the requirements for Standard Spend Down that are outlined in these rules and those of the TennCare Bureau.

(g) TennCare Standard. That part of the TennCare program which provides coverage for Tennessee residents who are not eligible for Medicaid but who meet the requirements for TennCare Standard that are outlined in these rules and those of the TennCare Bureau.

(h) Transition Group. Existing Medicaid Medically Needy adults age twenty-one (21) or older enrolled as of October 5, 2007, who have not yet been assessed for transition to the Standard Spend Down Demonstration population for non-pregnant adults twenty-one (21) or older.

"REDLINE VERSION-RULE 1240-03-01-.02 DATED FEBRUARY 6, 2009"

Authority: *T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-3-158(d)(2)(D), 71-5-101, 71-5-103 and 71-5-111; Acts 2007, Ch 31, § 11; 42 U.S.C. § 423, 42 U.S.C. §§ 601 et seq.; 42 U.S.C. §§ 1382 et seq.; 42 U.S.C. §§ 1395 et seq.; 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396a(e)(4); 42 U.S.C. § 1396r, 42 U.S.C. § 1396u-1; 42 C.F.R. § 435.4; PL 101-508 § 5103(e); PL 98-21 § 134 and PL 100-203 § 9116, and PL 104-193, and TennCare II Medicaid Section 1115 Demonstration Waiver.* ***Administrative History:*** *Original rule filed June 14, 1976; effective July 14, 1976. Amendment filed April 23, 1997; effective July 7, 1997. Public necessity rule filed July 2, 2007; effective through December 14, 2007. Amendment filed September 25, 2007; effective December 9, 2007. Public necessity rule filed January 24, 2008; effective through July 7, 2008. Amendment filed April 22, 2008; effective July 6, 2008.*

"REDLINE VERSION-RULE 1240-03-03-.02 DATED JANUARY 8, 2009"

RULES
OF
TENNESSEE DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

CHAPTER 1240-03-03
TECHNICAL AND FINANCIAL ELIGIBILITY
REQUIREMENTS FOR MEDICAID

1240-03-03-.02 TECHNICAL ELIGIBILITY FACTORS. To be eligible for Medicaid, families or individuals, whether classified as Categorically Needy or Medically Needy, must meet the following requirements, where applicable:

(1) Children otherwise covered under 1240-03-02-.02(3) or adults must not be inmates of a public institution, as that term is defined by Federal regulations and policy.

(2) An aged individual must be at least 65 years of age.

(3) A blind individual must meet the definition of blindness as contained in Title II and XVI of the Social Security Act relating to OASDI and SSI, 42 C.F.R. §435.530.

(4) A disabled individual must meet the definition of permanent and total disability as contained in Titles II and XVI of the Social Security Act relating to OASDI and SSI. Eligibility based on disability is determined in accordance with requirements set out by Titles XVI and XIX of the Social Security Act , 42 C.F.R. §§435.540, 435.541, and 435.911. As Tennessee is a 1634 State, the disability decision made by the Social Security Administration (SSA) for Supplemental Security Income (SSI) applicants is binding on the State Agency's decision for Medicaid only based on disability except when the individual applies for:

(a) Medicaid only and has not applied for SSI or has applied for SSI but was ineligible for a reason other than disability; or

(b) SSI at the Social Security Administration and applies to the State Agency for Medicaid only and the Social Security Administration does not make a disability determination within 90 days from the date of application for Medicaid only; or

(c) Medicaid only and alleges that a different or additional disabling condition exists and was not considered by the Social Security Administration; or

(d) Medicaid only more than 12 months after SSI disability denial and alleges that the disabling condition has changed or deteriorated or applies in less than 12 months of the Social Security Administration's determination alleging his/her condition has changed/deteriorated but the Social Security Administration refused to consider these new allegations and/or he/she is no longer financially or technically (other than disability) eligible for SSI.

(5) An individual must be a citizen of the United States, a naturalized citizen, certain American Indians born outside of the United States, or a qualified alien, unless applying for emergency medical services assistance as an illegal or undocumented alien or one lawfully admitted for residence who is not aged, blind, disabled, or under age eighteen (18). Aliens who entered the United States on or after August 22, 1996 have a five (5) year bar before potential eligibility for TennCare Medicaid unless they meet the exceptions to the five (5) year bar as outlined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).

(a) Each applicant/recipient is required to provide documentary evidence of citizenship and identity when applying for medical assistance. This requirement shall not apply to an individual declaring to be a citizen or national of the United States if they are:

1. A recipient of Medicare; or

2. A recipient of Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI); or

3. A child who is a recipient of foster care or adoption assistance under Title IV-B of the Social Security Act; or

4. A child who is a recipient of foster care or adoption assistance under Title IV-E of the Social Security Act.

(b) All documents must be originals or certified by the issuing agency.

(6) A child up to age twenty-one (21) or a pregnant woman.

(7) An individual must be a resident of the State of Tennessee, as defined by federal regulations at 42 C.F.R. § 435.403, Tennessee Code Annotated § 71-5-120, and as further defined by the Bureau of TennCare.

~~(8) Reserved.~~

(8) By accepting medical assistance through the Medicaid program, every recipient is deemed to assign to the State of Tennessee all third party insurance benefits or other third party sources of medical support or benefits. Failure to cooperate in establishing the paternity of dependent children, or in securing or collecting third party medical insurance, benefits or support is grounds for denying or terminating medical eligibility.

~~(9) By accepting medical assistance through the Medicaid program, every recipient is deemed to assign to the State of Tennessee all third party insurance benefits or other third party sources of medical support or benefits. Failure to cooperate in establishing the paternity of dependent children, or in securing or collecting third party medical insurance, benefits or support is grounds for denying or terminating medical eligibility.~~

(9) Asset Disregards for Qualifying Long Term Care Insurance Policies

(a) Individuals who purchase a qualified long term care insurance policy may have certain assets disregarded in the determination of eligibility for TennCare Medicaid. The Department of Human Services (DHS) shall disregard an individual's assets up to the amount of payments made by the individual's qualifying long-term care insurance policy for services covered under the policy at the time of TennCare application.

(b) The amount of the individual's assets properly disregarded under these provisions shall continue to be disregarded through the lifetime of the individual.

(c) Assets which were disregarded for purposes of Medicaid eligibility determination during the person's lifetime are also protected from estate recovery. When the amount of assets disregarded during the person's lifetime was less than total benefits paid by the qualified long term care insurance policy, additional assets may be protected in the estate recovery process up to the amount of payments made by the individual's qualifying long term care policy for services covered under the policy. If no assets were disregarded during the person's lifetime, the personal representative may designate assets to protect from estate recovery up to the lesser of the two options specified

above, even if a qualified long term care policy's benefits were not completely exhausted.

(10) Institutionalized individuals in a medical institution (i.e., one organized to provide medical care, including nursing and convalescent care) must be continuously confined for thirty (30) consecutive days prior to attaining Medicaid eligibility based on institutionalization. Medicaid eligibility is retroactive to the later of: a) the date of admission; or b) the date of application when thirty (30) consecutive days of institutionalization is met. Coverage of Home and Community Based Services (HCBS) requires a determination that the individual needs, and is likely to receive, HCBS services for thirty (30) consecutive days going forward.

(11) As a condition of receiving medical assistance through the Medicaid program, each applicant or recipient must furnish his or her Social Security Number (or numbers, if he/she has more than one) during the application process. If the applicant/recipient has not been issued a number, he/she must assist the eligibility worker in making application for a number or provide verification that he/she has applied for a number and is awaiting its issuance.

Authority: *T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102, 71-5-106, 71-5-107, 71-5-109, 71-5-120 and 71-5-141; 8 U.S.C. §§ 1611, 1612, 1613, and 1641, 42 U.S.C. § 402, 42 U.S.C. § 423, 42 U.S.C. § 672, 42 U.S.C § 673, 42 U.S.C. § 1315, 42 USC §§ 1382c(a)(3) and (4), 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396a(a)(10)(A)(ii)(I) and (V)(VI); 42 U.S.C. § 1396b(v)(1) and (x)(1), (2) and (3); 42 U.S.C. § 1396d and 42 U.S.C. 1396n(c); 42 C.F.R. §§ 435.210, 435.217, 435.300, 435.301, 435.403, 435.406, 435.407, 435.530, 435.540, 435.622, and 435.914(c); PL 104-193 §§ 401, 402, 403 and 431, PL 109-432, Division B, Title IV § 405, December 20, 2006, and PL 109-171 § 6036; 71 FR 39214 (July 6, 2006); and TennCare Medicaid Section 1115 Demonstration Waiver.* ***Administrative History:*** *Repeal and new rule filed June 14, 1976; effective July 14, 1976. Amendment filed September 15, 1977; effective October 14, 1977. Amendment filed June 9, 1981; effective October 5, 1981. Amendment filed August 28, 1981; effective November 30, 1981. Amendment filed November 30, 1981; effective January 14, 1982. Repeal and new rule filed August 17, 1982; effective September 16, 1982. Amendment filed September 4, 1984; effective October 4, 1984. Amendment filed September 19, 1985; effective October 19, 1985. Amendment filed May 23, 1986; effective August 12, 1986. Amendment filed July 31, 1987; effective September 13, 1987. Amendment filed August 9, 1989; effective September 23, 1989. Amendment filed August 17, 1992; effective October 8, 1992. Amendment filed December 30, 1993; effective March 15, 1994. Amendment filed June 5, 1995; effective August 18, 1995. Amendment filed May 1, 2003; effective July 15, 2003. Public Necessity Rule filed June 1, 2007; expired November 13, 2007. Public necessity rule filed July 2, 2007; effective through December 14, 2007. Amendment filed August 30, 2007; effective November 13, 2007. Amendment filed December 11, 2007; effective February 24, 2008. Amendments filed April 22, 2008; effective July 6, 2008.*